Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-278
Employees' Manual, Title 8
Medicaid Appendix

October 26, 2007

MATERNAL HEALTH CENTER MANUAL TRANSMITTAL NO. 07-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***MATERNAL HEALTH CENTER MANUAL***, Title Page, revised; Chapter III, *Provider-Specific Policies*, Title Page, new; Table of Contents (page 1), new; pages 1 through 30, new; and the following forms:

470-2942	*Medicaid Prenatal Risk Assessment*, revised
CMS-1500	*Health Insurance Claim Form*, revised
470-3969	*Claim Attachment Control*, revised
	Remittance Advice, unchanged

Summary

Chapters on coverage and limitations and on billing and payment for maternal health services are combined and revised to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters.

Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make the chapters quicker to load on line and easier to read and update.

Chapter III is also revised to:

- Update the coverage of the VFC program.
- Update the prenatal risk assessment form, claim form, and the claim attachment form.

Date Effective

October 1, 2007

Material Superseded

Remove the entire Chapter E and Chapter F from the ***MATERNAL HEALTH CENTER MANUAL*** and destroy them. This includes the following:

Page	Date
Title Page	Undated
Contents (Page 4)	November 1, 2004
Contents (Page 5)	June 1, 2004
Chapter E	
1, 2	February 1, 2002
3-6, 6a	November 1, 2004
7, 8 (470-2942)	5/03

9, 10	February 1, 2002
11	January 1, 2004
12	April 1, 2003
13, 14	February 1, 2002
15	April 1, 2003
16, 17	July 1, 2004
Chapter F	
1-7	April 1, 1998
8	July 1, 2003
9, 10 (HCFA-1500)	12/90
10a (470-3969)	7/03
11, 12	April 1, 1998
13, 14	Undated
15-17	April 1, 1998
18	April 1, 2003
19 (470-3744)	10/02
20	Undated
21 (470-0040)	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise

Iowa Department of Human Services

Maternal Health Center Provider Manual

Medicaid Enterprise

Iowa Department of Human Services

III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. MATERNAL HEALTH CENTERS ELIGIBLE TO PARTICIPATE

A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services. Team members must be employed by or under contract with the center. The team must have at least:

- A physician.
- A registered nurse.
- A licensed dietitian.
- A person with at least a bachelor's degree social work, counseling, sociology, or psychology.

The prenatal and postpartum care shall be in accordance with the latest edition of the Standards for Obstetric-Gynecologic Services published by the American College of Obstetricians and Gynecologists.

B. COVERAGE OF SERVICES

Complete a risk assessment using form 470-2942, *Medicaid Prenatal Risk Assessment*, twice during a Medicaid member's pregnancy:

- Upon entry into care and
- At approximately 28 weeks.

Medical services shall be:

- Provided under the supervision of a physician.
- Provided by:
  - A physician,
  - A physician assistant, or
  - A nurse practitioner.

These people may be employed by or under contract to the center. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of their profession, as defined by the Code of Iowa. Provide trimester and postpartum reports to the referring physician.

Iowa Department of Human Services

MEDICAID PRENATAL RISK ASSESSMENT

Primary provider name	Provider phone number	Date
Client name	Phone number	Client date of birth
Address		Medicaid ID number

Gestational age at initial assessment: Weeks Date	Gestational age at rescreen: Weeks Date

Instructions: Write the score that applies to each risk factor. (* For risk factor definitions and nutrition screen, see back.)

Risk Factor/Value	A Score Initial
Maternal age 20-40 = 0 16-19 or >40 = 4 ≤ 15 = 10	
Education GED or 12 = 0 ≤ 11 = 2 ≤ 8 = 4	
Marital status married = 0 single, divorced, separated = 2	
Height >5 feet = 0 ≤ 5 feet = 3	
Prepregancy weight low (BMI < 19.8) = 2 obese (BMI > 29.0) = 2	
AB 1st trimester * < 3 = 0 ≥ 3 = 1	
AB 2nd trimester * none = 0 1 = 5 ≥ 2 = 10	
Race white = 0 black = 2 other = 1	
Cone biopsy/LEEP no = 0 yes = 3	
Uterine anomaly * no = 0 yes = 10	
Previous SGA baby no = 0 yes = 10	
Hx preterm labor * or preterm delivery no = 0 yes = number x 10	
Bleeding gums/never been to dentist no = 0 yes = 5	
Cigarette use/day 1 cig – 1/2 ppd = 1 > 1/2 ppd = 4	
Illicit drug use * (this pregnancy) no = 0 yes = 5	
Alcohol use * (this pregnancy) no = 0 yes = 2	
Initial prenatal visit * < 16 wks = 0 > 16 wks = 2	
Poor social situation * no = 0 yes = 5	
Children ≤ 5 years at home 0 or 1 = 0 ≥ 2 = 2	
Employment * none = 0 outside school/work = 1 heavy work = 3	
Last pregnancy within 1 year of present pregnancy no = 0 yes = 1	
Subtotal A	

Risk Factor Current Pregnancy/Value	B1 Initial OB	B2 Rescreen 28 wks+
Bacteriuria,* chlamydia, GC this pregnancy no = 0 yes = 3		
Pyelonephritis * no = 0 yes = 5		
Fibroids no = 0 yes = 3		
Presenting part engaged < 36 weeks no = 0 yes = 3		
Uterine bleeding ≥ 12 weeks * no = 0 yes = 4		
Cervical length < 1 cm < 34 weeks no = 0 yes = 4		
Dilation ≥ 1 cm * no = 0 yes = 4		
Uterine irritability * ≤ 34 weeks no = 0 yes = 4		
Placenta previa at < 30 weeks no = 0 yes = 4		
Oligohydramnios no = 0 yes = 10		
Polyhydramnios no = 0 yes = 10		
Multiple pregnancy no = 0 yes = 10+		
Surgery (abdominal * ≥ 18 weeks or cerclage) no = 0 yes = 10		
Depression ♦ Over the past 2 weeks have you ever felt down, depressed or hopeless? ♦ Over the past 2 weeks have you felt little interest or pleasure in doing things? (to either) no = 0 yes = 10		
Weight gain at 22 weeks ≥ 7 lb. = 0 < 7 lb. = 2		
Weight loss < 5 lb. = 0 ≥ 5 lb. = 3		
Urine protein 0/trace = 0 1+ = 2 > 1+ = 5		
Hypertension * or HTN medications no = 0 yes = 10		
Hemoglobin Hematocrit < 11 = 3 < 33 = 3		
Subtotal B1 and B2		

Other: _____ Additional risk factors indicating need for enhanced services. (See back for examples.) Points need not total 10.

Subtotal A		Subtotal A	
Subtotal B1	+	Subtotal B2	+
Total 1st OB		Total 28 weeks screen	

Total score of 10 points or more = high risk for preterm delivery. Check all enhanced antepartum management services that apply and indicate who will be the primary provider of each service.

- ❑ Care coordination _____
- ❑ Health education _____
- ❑ Psychosocial _____
- ❑ High risk follow-up _____
- ❑ Nutrition counseling _____
- ❑ Home visit _____
- ❑ Oral health _____
- ❑ Medical transportation _____

Signature of primary provider Date	Client signature: Release of information Date
Date of referral for WIC services:	(State WIC Office – 1-800-532-1579)

Risk Factor Definition

AB 1st trimester: More than three spontaneous or induced abortions at less than 13 weeks gestation. (Do not include ectopic pregnancies.)

AB 2nd trimester: Spontaneous or induced abortion between 12 and 19 weeks gestation.

Uterine anomaly: Bicornate, T-shaped, or septate uterus, etc.

Dental visit: Routine preventive dental care; not visit for emergency extraction, mouth trauma.

DES exposure: Exposure to diethylstilbesterol in utero. Patient who has anomalies associated with diethylstilbesterol receives points for this item and uterine anomaly.

Hx PTL: Spontaneous preterm labor during any previous pregnancies (whether or not resulting in preterm birth) or preterm delivery.

Hx pyelonephritis: One or more episodes of pyelonephritis in past medical history.

Illicit drug use: Any street drug use during this pregnancy, e.g., speed, marijuana, cocaine, heroin (includes methadone), huffing, or the recreational use of Rx or OTC drugs.

Alcohol use: Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking.

Initial prenatal visit: First prenatal visit at or after 16 weeks gestation.

Poor social situation: Personal or family history of abuse, incarceration, homelessness, unstable housing, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support system, low self esteem.

Employment:
Light work = part time or sedentary work or school
Heavy work = work involving strenuous physical effort, standing, or continuous nervous tension, such as, nurses, sales staff, cleaning staff, baby-sitters, laborers

Bacteriuria: Any symptomatic or asymptomatic urinary tract infection, i.e., 100,000 colonies in urinalysis.

Pyelonephritis: Diagnosed pyelonephritis in the current pregnancy. (Give points for pyelonephritis only, not both pyelonephritis and bacteriuria.)

Bleeding after 12th week: Vaginal bleeding or spotting after 12 weeks of gestation of any amount, duration, or frequency which is not obviously due to cervical contact.

Dilation (Internal os): Cervical dilation of the internal os of one cm or more at 34 weeks gestation.

Uterine irritability: Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks.

Surgery: Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy.

Hypertension: Two measurements showing an increase of systolic pressure of 30 mgHg above baseline, an increase in diastolic pressure of 15 mgHg above baseline, or both.

Nutritional Risk Factor Assessment and Definitions

Instructions: Check nutrition counseling if any of the factors below indicate nutritional risk.

Anemia:

Hgb < 11 or Hct < 33 (weeks 1-13 and weeks 27-40+)
Hgb < 10.5 or Hct < 32 (weeks 14-26)

Inappropriate nutrition practices:

- Consuming potentially harmful dietary supplements (includes excessive doses and those that may be toxic or harmful in other ways)
- Consumes diet very low in calories or essential nutrients (includes vegan diet defined as consuming only fruits, vegetables, and grains; macrobiotic diet; food faddism; and impaired calorie intake or nutrient absorption following bariatric surgery)
- Pica
- Inadequate iron supplementation (< 30 mg/day)
- Consuming foods potentially contaminated with pathogenic bacteria (raw seafood, meat, poultry, and eggs or any foods containing these products; raw sprouts; undercooked meat, poultry, and eggs; unpasteurized milk or foods containing it; soft cheeses such as feta, Brie, Camembert, blue-veined and Mexican-style cheese; unpasteurized fruit or vegetable juices; and hot dogs and luncheon meats unless reheated until steaming hot)

Examples of additional risk factors:

Medical	♦ Autoimmune disease ♦ Current eating disorder, fasting, skipping meals ♦ Diabetes ♦ Febrile illness ♦ Gestational diabetes ♦ Heart disease ♦ History of gastric bypass ♦ HIV ♦ Hyperemesis ♦ Psychiatric disorder ♦ Renal disease ♦ Seizure disorders ♦ Thyroid disease ♦ Type I diabetes
OB History	♦ Caesarean section ♦ Infertility ♦ Perinatal loss
Psychosocial	♦ Ambivalent, denying, or rejecting of this pregnancy ♦ Child care stress ♦ Cultural or communication barriers ♦ History of mental illness ♦ Not compliant with visit or healthy pregnancy behaviors (or not expected to be compliant without additional intervention) ♦ Teen pregnancy

Payment will be made for:

- Prenatal and postpartum medical care.
- Care coordination and health education services for patients who are not determined high-risk.
- More intense prenatal services for patients determined high-risk. These services include additional health education, nutrition counseling, social services, additional care coordination, and a postpartum home visit. Services are provided as medically necessary.

1. Prenatal Risk Assessment

Determine risk for pregnant Medicaid members upon entry into care using form 470-2942, *Medicaid Prenatal Risk Assessment*. To view a sample of this form on line, click here.

When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care or when an increase in the pregnant woman's risk status is indicated.

The Iowa Departments of Human Services and Public Health have jointly developed the *Medicaid Prenatal Risk Assessment* to help the clinician determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

The form categorizes the risk factors and assigns a score value related to the seriousness of the risk. In individual cases, the clinician may determine that the value the form assigns is not appropriate and may choose a lesser value.

To determine a woman's risk status during the current pregnancy, add the total score value on the left side and either the B_1 column (initial visit score value) or the B_2 column (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

When a high-risk pregnancy is reflected, inform the woman and provide enhanced services. (See Enhanced Services to High-Risk Women.) Give a copy of the *Medicaid Prenatal Risk Assessment* to the agency providing enhanced services and keep a copy in the patient's medical records.

a. Risk Factors Related to History

The left side of the *Medicaid Prenatal Risk Assessment* includes medical, historical, environmental, or situational risk factors. A description of many of the risk factors is located on the back of the form. Included are AB first trimester, AB second trimester, uterine anomaly, HX pyelonephritis, illicit drug use, and poor social situation.

Give cigarette smoking a point value if the person smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."

Indicate the risk factor "Last birth within 1 year," when the patient has been pregnant within 12 months of the beginning of the present pregnancy.

b. Risk Factors Related to Current Pregnancy

The right side of the form includes risk factors related to the current pregnancy. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the mid to last trimester. For this reason these risk factors are assessed twice during the pregnancy on the form.

A description of the following risk factors is located on the back of the form: bacteriuria, pyelonephritis, bleeding after twelfth week, dilation, and uterine irritability.

Depression has an impact on the development and management of pregnancy related complications. Untreated depression has been associated with unfavorable health behaviors in pregnancy and subsequent fetal growth restrictions, preterm delivery, placental abruption, or newborn irritability.

Using the following two questions to screen for depression may be as effective as more lengthy tools.

- Over the past two weeks, have you ever felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

A positive response to both questions suggests the need for further evaluation. A positive response to one of these questions is sufficient to provide services for a high-risk pregnancy.

(Source: *Psychosocial Risk Factors: Prenatal Screening and Interventions*, ACOG Committee Opinion No 343, American College of Obstetricians and Gynecologists, Obstet Gynocal 2006, 108.469-77.)

Use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These are common examples only and are not meant to be a comprehensive list.

2. Services to Low-Risk Women

The services provided to low-risk woman include:

- Prenatal and postpartum medical care.
- Health education services provided by a registered nurse, which includes:
  - Importance of continued prenatal care.
  - Normal changes of pregnancy:
    - Maternal changes
    - Fetal changes
  - Self-care during pregnancy.
  - Comfort measures during pregnancy.
  - Danger signs of pregnancy.
  - Labor and delivery:
    - Normal process of labor
    - Signs of labor
    - Coping skills
    - Danger signs
    - Management of normal labor
  - Preparation for baby:
    - Feeding
    - Equipment
    - Clothing
  - Education on the use of over-the-counter drugs.
  - Education about HIV prevention.

- Care coordination services include:
  - Presumptive eligibility determinations.
  - Risk assessment.
  - Arrangements for prenatal classes.
  - Arrangements for delivery as appropriate.
  - Referral to WIC.
  - Referral to dental services.
  - Referral to physician or mid-level practitioners.
  - Referral for hepatitis screen.
  - Referral for other services as necessary.
  - Completion of the DHS multiprogram application. (Centers cannot bill for completion of the Medicaid application)
- Transportation to receive prenatal and postpartum services that is not otherwise payable under the Medicaid program.
- Dental hygiene services within the scope of practice defined by the Iowa Board of Dental Examiners for dental hygienists providing services under public health supervision.

Education can be done in conjunction with the use of brochures and pamphlets. Encourage clients to enroll in community prenatal classes.

Some families will need assistance to obtain Medicaid services. Care coordination is the process of linking Medicaid members to the health care system. The service centers on the process of collecting information on the health needs of the member, making referrals as needed, and assisting families in activating the examination, diagnosis, treatment loop.

Activities commonly understood as allowable care coordination activities include assisting members in gaining access to services and monitoring to assure that needed services are received. Care coordination does not include payment of these services.

Care coordination related to a direct service is considered part of the direct service. Activities must be considered a part of the direct service if they are included in the pre and post visit services. This direct care related activity should not be billed separately as care coordination service.

NOTE: CMS policy states, "payments for allowable Medicaid case management services must not duplicate payments that have been, or should have been, included as part of a **direct** medical service.... Activities that are considered integral to, or an extension of, the specific covered service are included in the rate set for the direct service, therefore they should not be claimed as case management. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral as a case management service. These activities are properly paid for as part of the medical service."

Care coordination services shall be provided by:

- A registered nurse;
- A person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology;
- A person with a degree in dental hygiene;
- A licensed practical nurse; or
- A paraprofessional working under the direct supervision of a health professional.

3. Enhanced Services to High-Risk Women

Additional services are available to women determined to have high-risk pregnancies. The services included in the Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, Caring for the Future: The Content of Prenatal Care.

National studies have shown that low-income women who receive these services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting improved birth outcomes for Medicaid-eligible pregnant women in Iowa.

Maternal health centers that provide enhanced services work with physicians to provide services to higher risk pregnant women. This process allows patients determined to be at high risk to access additional services that Medicaid does not provide under other circumstances. It is expected that the primary medical care provider will continue to provide the medical care.

The enhanced services include:

- More intense care coordination services
- More intense health education services
- Nutrition services
- Psychosocial services
- A postpartum home visit

a. Care Coordination

The following care coordination services shall be provided to women with high-risk pregnancies in addition to the services for low-risk women:

- Developing an individualized plan of care based on the member's needs, including pregnancy, personal, and interpersonal issues. Developing the plan includes:
  - Counseling (such as coaching, supporting, education, listening, encouraging, and feedback), and
  - Referral and assistance for obtaining other specified services, such as mental health and domestic abuse.
- Ensuring that the member receives all components as appropriate (medical, education, nutrition, psychosocial, and postpartum home visit).
- Risk tracking.

b. Health Education

A registered nurse shall provide health education services. In addition to the education services listed earlier, education on the following topics should be provided as appropriate:

- High-risk medical conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, gestational diabetes, chronic urinary conditions, genetic disorders, and anemia.
- Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension.
- Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases.
- Smoking cessation. Refer to Quitline Iowa at 800-784-8669 or on the web at http://www.quitlineiowa.org/.

- Alcohol use.
- Drug use.
- Education on environmental and occupational hazards.
- High-risk sexual behavior.

You may make referrals to:

- Programs for stopping smoking or the use of alcohol or drugs.
- Psychosocial services for high-risk parenting issues or home situations, stress management, communication skills and resources, or self esteem.

c. Nutrition Services

A licensed dietitian shall provide nutrition services. Nutrition assessment and counseling shall include:

- Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss the client's attitude about breastfeeding.
- At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- Development of an individualized nutritional care plan.
- Referral to food assistance programs, if indicated.
- Nutritional interventions:
  - Nutritional requirements of pregnancy as linked to fetal growth and development.
  - Recommended dietary allowances for pregnancy.
  - Appropriate weight gain.
  - Vitamin and iron supplements.
  - Information to make an informed infant feeding decision.
  - Education to prepare for the proposed feeding method and the support services available for the mother.
  - Infant nutritional needs and feeding practices.

d. Psychosocial Services

Psychosocial assessment and counseling shall include:

- A psychosocial seeds assessment including a profile of the mother's:
  - Demographic factors,
  - Mental and physical health history and concerns,
  - Adjustment to pregnancy and future parenting, and
  - Environmental needs.
- A profile of the mother's family composition, patterns of functioning, and support systems.
- An assessment-based plan of care.
- Risk tracking.
- Counseling and anticipatory guidance as appropriate.
- Referral and follow-up services.

Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.

e. Home Visit

A registered nurse shall provide a postpartum home visit within two weeks of the child's discharge from the hospital (ideally in the first week). This visit shall include:

- An assessment of the mother's health status.
- Discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome.
- Family planning.
- A review of parenting skills, including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant.
- An assessment of the infant's health.
- A review of infant care, including feeding and nutritional needs, breast-feeding support, recognition of illness, accident prevention, immunizations, and well-child care.
- Identification and referral to community resources as needed.

D. BASIS OF PAYMENT FOR MATERNAL HEALTH CENTERS

Maternal health centers are reimbursed on a fee-for-service basis. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. For some codes, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit. If the code is a 30-minute unit, round remainders of 16 minutes or more up to the next unit.

E. RECORDS

The documentation for each "patient encounter" shall include the following (when appropriate):

- Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- Specific procedures or treatments performed.
- Medications or other supplies.
- Member's progress, response to and changes in treatment, and revision of diagnosis.
- Information necessary to support each item of service reported on the Medicaid claim form:
  - Date of service.
  - Name of member.
  - Name of provider agency and person providing the service.
  - Nature, extent, or units of service. Maintain a record of the time to support the units billed.
  - Place of service.

The requirements for documenting medical transportation services include the following:

- Date of service
- Member's name
- Address of where member was picked up
- Destination (medical provider's name and address)
- Invoice of cost
- Mileage if the transportation is paid per mile

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to members' medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

F. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Services or charges cannot be fragmented for each procedure code billed. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

1. Maternity Care

Code	Description
59425	Antepartum care only; 4 to 6 visits
59426	Antepartum care only; 7 or more visits
99420	Completion of *Medicaid Prenatal Risk Assessment*, form 470-2942
S9465	Diabetic management program, dietitian visit
90471	Immunization administration
90472	Immunization administration, each additional vaccine

Code	Description
H0046	Mental health services, not otherwise specified, per encounter
S9123	Nursing visit in the home, per hour
S9470	Nutrition counseling dietitian visit
59430	Postpartum care only (separate procedure)
H1002	Prenatal care, at-risk care coordination, 30-minute unit
H1003	Prenatal care, at-risk service education, 15-minute unit
S9127	Social work visit in the home (encounter code)
81025	Urine pregnancy test, by visual color comparison

New Patient

Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ A problem-focused history; ♦ A problem focused examination; and ♦ Straightforward medical decision-making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ An expanded problem-focused history; ♦ An expanded problem-focused examination; and ♦ Straightforward medical decision-making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient or family.

Code	Description

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems) and the patient's and family's needs. Usually, the presenting problems are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient or family.

Established Patient

Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ a problem-focused history; ♦ a problem-focused examination; ♦ straightforward medical decision-making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ an expanded problem-focused history; ♦ an expanded problem-focused examination; ♦ medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problems are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient or family.

Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ a detailed history; ♦ a detailed examination; ♦ medical decision making of moderate complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ a comprehensive history; ♦ a comprehensive examination; ♦ medical decision making of high complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient or family.

Do not submit a copy of the *Medicaid Prenatal Risk Assessment*, 470-2942. Maintain the form in the medical file.

2. Injections

Immunizations are usually given in conjunction with a medical service. Immunization procedures include the supply of related materials. Bill the vaccine administration codes in addition to the CPT code.

Provide immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are:

Code	Description
90633	Hepatitis A, pediatric/adolescent (2-dose schedule)
90649	Human Papilloma virus (HPV)
90658	Influenza virus vaccine, age 3 years and older
90707	Measles, mumps, and rubella virus vaccine
90710	Measles, mumps, rubella, varicella (MMRV)
90714	Tetanus and diphtheria toxoids (TD), adsorbed, preservative free, age 7 years and older
90715	Tetanus, diphtheria toxoids and acellular pertussis (TDaP), age 7 years and older
90716	Varicella vaccine
90718	Tetanus and diphtheria toxoids adsorbed, 7 years or older (TD)
90734	Meningococcal conjugate vaccine
90743	Hepatitis B vaccine; adolescent (two-dose schedule), for intramuscular use
90744	Hepatitis B vaccine; pediatric/adolescent dosage (three-dose schedule), for intramuscular use
90746	Hepatitis B vaccine; age 20 years and older

For VFC vaccine, bill code 90471 and 90472 for vaccine administration in addition to the CPT code. Charge your usual and customary charge for the administration 90471 and 90472. The charges in box 24F should be "0" for the vaccine.

NOTE: 90473 (immunization administration by oral or nasal route) cannot be used with 90471.

When a member receives a vaccine outside of VFC coverage, Medicaid will provide reimbursement for the vaccine. Codes for other injections:

Code	Description
90782	Injection of medication
J2790	Rhogam, RHO D immune globulin

3. Local Transportation

In the diagnosis code area of the claim form, use diagnosis code V68.9.

Code	Description	Unit
A0080	Non-emergency transportation; vehicle provided by volunteer (individual or organization), with no vested interest	Per round trip
A0100	Non-emergency transportation; taxi	Per round trip
A0110	Non-emergency transportation; bus, intra or interstate carrier	Per round trip
A0130	Non-emergency transportation; wheelchair van	Per round trip
A0160	Non-emergency transportation, by caseworker or social worker	Per round trip
A0170	Transportation; parking fees, tolls, other	

Use the following code for customers enrolled in a Medicaid HMO.

Code	Description	
T2002	Non-emergency transportation	Per day

4. Oral Health Services

In the diagnosis area of the claim form, use diagnosis code 528.9. NOTE: For dental coding, "child" means age 11 and younger and "adult" means age 12 and older.

Code	Procedure	Comment
D0150	Initial screening evaluation	
D0120	Screening evaluation (periodic)	Once every six months
D1110	Adult prophylaxis	
D1120	Child prophylaxis	
D1203	Fluoride application, child	Three times annually
D1204	Fluoride application, adult	Three times annually
D1206	Topical fluoride varnish	
D1310	Nutritional counseling for the control and prevention of oral disease	15-minute unit

Code	Procedure	Comment
D1320	Tobacco counseling for the control and prevention of oral disease	15-minute unit
D1330	Oral hygiene instructions (home care, tooth brushing, flossing and special hygiene aids)	15-minute unit
D1351	Sealant, per tooth	

G. CLAIM FORM

Bill for maternal health center services on the *Health Insurance Claim Form*, CMS-1500. To view a sample of this form on line, click here.

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED**. Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED**. Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
2.	PATIENT'S NAME	**REQUIRED**. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL**. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL**. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN.** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**SITUATIONAL.** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN.** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
10d.	RESERVED FOR LOCAL USE	**OPTIONAL.** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED.** If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL.** No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL.** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	**SITUATIONAL.** Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL**. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL**. No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL**. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		**OPTIONAL.** No entry required.
17b.	NPI	**SITUATIONAL**. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
19.	RESERVED FOR LOCAL USE	**OPTIONAL.** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL**. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED**. Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL.** If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE	**REQUIRED**. Enter month, day, and year under both the "From" and "To" columns for each procedure, service, or supply. If the "From-To" dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a monthly basis, spanning or overlapping billing months could cause the entire claim to be denied.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	**REQUIRED**. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED**. Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED**. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED**. Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED**. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL**. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**OPTIONAL**. No entry required.
24. J	RENDERING PROVIDER ID #	**SITUATIONAL.** The "rendering provider" is the practitioner who provided, supervised, or ordered the service. In the lower portion, enter the NPI of the provider rendering the service when the NPI given in field 33 is that of a group or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE.** Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	**OPTIONAL**. No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED**. Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL**. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED**. Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED**. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED.** Enter the name and address associated with the rendering provider.
32a.	NPI	**OPTIONAL.** Enter the NPI of the facility where services were rendered.
32b.		**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED**. Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification or during enrollment. To view the ZIP code provided, access imeservices.org.
33a.	NPI	**REQUIRED**. Enter the ten-digit NPI of the billing provider. A provider that does not meet the definition of "health care provider" and therefore does not meet the criteria to receive an NPI should enter the ten-digit provider number assigned by IME (begins with "X00"). If this number identifies a group or an individual provider other than the provider of service, the rendering provider's NPI must be entered in field 24J for each line. NOTE: The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the NPI provided, access imeservices.org.
33b.		**REQUIRED**. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, access imeservices.org.

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Staple the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click here.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

Iowa Department of Human Services

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

NPI Billing Provider Number

Member Name _____

Member State ID Number

Date of Service _____/_____/_____

Type of Document

_____

_____

_____

Return this document with attachments to:

IME Claims
P.O. Box 150001
Des Moines, IA 50315

470-3969 (Rev. 7/07)

Iowa Department of Human Services

Screening Components by Age

Age	Infancy							Early Childhood					Late Childhood					Adolescence			
	2-3 [1] days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
HISTORY																					
Initial/Internal	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAM	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
MEASUREMENTS																					
Height/Weight	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Head Circumference	★	★	★	★	★	★	★	★	★	★											
Blood Pressure											★	★	★	★	★	★	★	★	★	★	★
NUTRITION ASSESS/EDUCATION	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH [2]																					
Oral Health Assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dental Referral							★			★	Every six months										
SENSORY SCREENING																					
Vision	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O	O	S	O	O
Hearing	O	S	S	S	S	S	S	S	S	S	S	O	O	S	S	S	O	S	S	O	S
DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT [3]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
IMMUNIZATION [4]	★		★	★	★			★	★			✪		★	★	★	✪				
PROCEDURES																					
Hgb/Hct				✪															✪		
Urinalysis													★						✪		
Metabolic screening [5]	★																				

KEY: ★ To be performed ✪ Perform test once during indicated time period

S Subjective, by history **O** Objective, by a standard testing method

Continued on next page.

HEMOGLOBINOPATHY	Only once (newborn screen) and offered to adolescents at risk.
TUBERCULIN TEST	For high-risk groups, annual testing is recommended. These are household members of persons with tuberculosis or others at risk for close contact with the disease: recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.
LEAD	Starting at 12 months, assess risk for high dose exposure.
GYNECOLOGIC TESTING	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
STD	When appropriate. (People with a history and risk factors for sexually transmitted diseases should be tested for chlamydia and gonorrhea.)
ANTICIPATORY GUIDANCE	Performed every visit.

[1] For newborns discharged in 24 hours or less after delivery.

[2] The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.

[3] By history and appropriate physical examination, if suspicious, by specific objective developmental testing.

[4] An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.

[5] The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia.

- Do not attach a paper claim.
- Mail the Claim Attachment Control with attachments to:

  Iowa Medicaid Enterprise
  PO Box 150001
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

H. REMITTANCE ADVICE

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of the *Remittance Advice* on line, click here.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

A detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact The IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NUMBER	DESCRIPTION
1.	Billing provider's name as specified on the *Medicaid Provider Enrollment Application*.
2.	*Remittance Advice* number.
3.	Date claim paid.
4.	Billing provider's Medicaid (Title XIX) number.
5.	*Remittance Advice* page number.
6.	Type of claim used to bill Medicaid.

NUMBER	DESCRIPTION
7.	Status of following claims: • **Paid.** Claims for which reimbursement is being made. • **Denied.** Claims for which no reimbursement is being made. • **Suspended.** Claims in process. These claims have not yet been paid or denied.
8.	Member's last and first name.
9.	Member's Medicaid (Title XIX) number.
10.	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
11.	Total charges submitted by provider.
12.	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
13.	Total amount of Medicaid reimbursement as allowed for this claim.
14.	Total amount of member copayment deducted from this claim.
15.	Medical record number as assigned by provider; 10 characters are printable.
16.	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
17.	Line item number.
18.	The first date of service for the billed procedure.
19.	The procedure code for the rendered service.
20.	The number of units of rendered service.
21.	Charge submitted by provider for line item.
22.	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
23.	Amount of Medicaid reimbursement as allowed for this line item.

NUMBER	DESCRIPTION
24.	Amount of member copayment deducted for this line item.
25.	Treating provider's Medicaid (Title XIX) number.
26.	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
27.	Remittance totals (found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid. • Number of denied original claims and amount billed by provider. • Number of denied adjusted claims and amount billed by provider. • Number of pended claims (in process) and amount billed by provider. • Amount of check.
28.	Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.